# Presumptive Eligibility for Pregnant Women

**Presumptive Eligibility Intake Form**

Name_____
Last First Middle

Are you a US Citizen? ____Yes ____No Are you a WY Resident? ____Yes ____No

**If you answered no to either of the above questions, the Qualified Provider cannot determine your eligibility. Please complete a Healthcare Coverage Application and submit it to your local DFS Office.**

Date of Birth_____ Social Security Number_____-____-_____
Month/Day/Year

Home Address _____
Street City State Zip

Mailing Address _____
If different than Home Address

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Message Phone (____) _____

Email Address _____

Are you married? ____Yes ____No

Do you have health insurance? ____Yes ____No Name of insurance provider _____

Have you seen a doctor for your pregnancy? ____Yes ____No Doctor's Name_____

When is the baby due? _____How many babies are due? ___ Is this your first pregnancy? ____ Yes____No

What is your monthly gross income? $_____ Does the baby's father live with you? ____Yes ____No

If yes, what is his monthly gross income? $_____

How many children, under the age of 18, live in your home? _____

If you are under 18 and live with your parent(s), how many parents do you live with? _____

Is either of them employed? ____Yes ____No What is your parent's monthly gross income? $_____

Is anyone in the family receiving child support? ____Yes ____No If yes, how much? $_____

_____ _____
Signature Date

July 2008

EqualityCare
Eligibility Unit